TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
PROFESSIONAL EMERGENCY SERVICE ASSOC. OF DESOTO

**Respondent Name**
NEW HAMPSHIRE INSURANCE COMPANY

**MFDR Tracking Number**
M4-17-1132-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
December 27, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Please review the entire narrative report . . . to find the elements required for ROS, PFSH, and HPI. . . . This of course will meet the requirement of two out of the three components of documentation for established patient visits."

**Amount in Dispute:** $425.55

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Regarding 99205. Documentation does not support the level billed. Provider must document all three of the following: Comprehensive history, comprehensive exam, and High complexity decision making. None of these is met. Documentation is better described as a 99204 however since the juris is a no down code state, we are unable to recommend an allowance."

**Response Submitted by:** Flahive, Ogden & Latson, Attorneys At Law, P.C.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 22, 2016 | New Patient Office Visit | $425.55 | $331.38 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out guidelines for work status reports.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P1 – (P12) – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - Z710 – [no description of this code was found with the submitted materials.]
   - 26469 – [no description of this code was found with the submitted materials.]
   - Z469 – [no description of this code was found with the submitted materials.]
   - Z559 – [no description of this code was found with the submitted materials.]
   - 15 – (150) PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 15 – (150) PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE."

   The respondent states:

   > Regarding 99205. Documentation does not support the level billed. Provider must document all three of the following: Comprehensive history, comprehensive exam, and High complexity decision making. None of these is met. Documentation is better described as a 99204 however since the juris is a no down code state, we are unable to recommend an allowance.

   The requestor asks that we "please review the entire narrative report . . . This of course will meet the requirement of two out of the three components of documentation for established patient visits."

   The primary disputed service is procedure code 99205, which represents the evaluation and management of a new patient, the code definition of which requires:

   - a comprehensive history,
   - comprehensive examination,
   - and medical decision making of high complexity.

   As opposed to an *established* patient visit, this code for a new patient visit requires not two components, but rather all three components to be documented; or *in the alternative*, documentation of sixty minutes or more of face-to-face time spent with the patient.

   Although initially the respondent states that "None of these is met," the respondent goes on to concede that the first two key elements of the code are both documented: a comprehensive history and comprehensive examination. However, the respondent asserts that only "a Moderate Complexity Level" was documented.

   To meet the requirement for high complexity of decision making the provider should document:

   - extensive (4 or more) diagnoses or treatment options,
   - a high level of risk of complications, morbidity or mortality,
   - reviewing/ordering an extensive amount or complexity of labs, images, tests, old records, or other data.

   Review of the submitted documentation finds that 4 diagnoses are present, qualifying as "extensive." However, the risk level to the patient was low (involving an acute, uncomplicated injury), and the amount of data reviewed was minimal (X-rays only). Accordingly, the complexity of medical decision making was low, not high, and does not qualify as one of the three key elements to support the level of service.

   While all three required key elements were not met, the code definition does allow alternatively in circumstances where counseling or coordination of care dominates more than 50% of the encounter (face-to-face or floor/unit time) that time may be considered the key or controlling factor to qualify for the level of service.

In this instance the provider documented that "The patient spent a total of 108 minutes in the center, with more than a minimum of 60 minutes of that time being face to face to face with medical staff and providers. The preparation of this report also required an additional 20 minutes of time."

As the time spent face-to-face with the patient dominated the patient encounter and exceeded the minimum 60 minute time requirement for the code definition, that time may be considered as the controlling factor to qualify for the level of service. The division therefore finds that the submitted documentation does support the level of service billed for evaluation and management code 99205.

The division concludes the insurance carrier's denial reasons are not supported. The provider's documentation supports the services as billed. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .

   (2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors. . . .

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor.

   The applicable division conversion factor for calendar year 2016 is $56.82.

3. Reimbursement is calculated as follows:

   - For evaluation code 99205, the relative value (RVU) for work of 3.17 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 3.22706. The practice expense (PE) RVU of 2.36 multiplied by the PE GPCI of 1.009 is 2.38124. The malpractice RVU of 0.29 multiplied by the malpractice GPCI of 0.772 is 0.22388. The sum of 5.83218 is multiplied by the division conversion factor of $56.82 for a MAR of $331.38.
   - Procedure code 99080 represents a work status report, a division-specific code paid per Rule §129.5(i), which requires that the amount of reimbursement shall be $15.
   - For procedure code 72110, the relative value (RVU) for work of 0.31 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.31558. The practice expense (PE) RVU of 1.03 multiplied by the PE GPCI of 1.009 is 1.03927. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.772 is 0.02316. The sum of 1.37801 is multiplied by the division conversion factor of $56.82 for a MAR of $78.30.

4. The total allowable reimbursement for the services in dispute is $424.68. The insurance carrier paid $93.30. The amount due the requestor is $331.38. This amount is recommended.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $331.38.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $331.38, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | Grayson Richardson | August 4, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.